Salmon Brook Dental
creating beautiful smiles

PATIENT INFORMATION:

First Name:_____ M. Initial _____ Last Name:_____

Address: _____

City: _____ _____ State: _____ Zip Code: _____

Home Ph: _____ Work: _____ Cell Ph: _____

Birth Date: _____ Soc Sec: _____ Email: _____

RESPONSIBLE PERSON (If other than patient)

First Name:_____ M. Initial _____ Last Name:_____

Address: _____

City: _____ _____ State: _____ Zip Code: _____

Home Ph: _____ Work: _____ Cell Ph: _____

Birth Date: _____ Soc Sec: _____ Email: _____

INSURANCE INFORMATION
(Primary)

Name of Insured: _____

Ins. SS#: _____

Ins DOB: _____

Employer: _____

Ins. Carrier: _____

Group #: _____

Member I.D.: _____

INSURANCE INFORMATION
(Secondary)

Name of Insured: _____ I

Ins. SS#: _____

Ins DOB: _____

Employer: _____

Ins. Carrier: _____

Group #: _____

Member I.D.: _____

Time 9:50 AM

Salmon Brook Dental Associates

Eaglesoft Medical History

Date 7/5/2017

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Salmon Brook Dental Associates, LLC
Financial Policies

We at Salmon Brook Dental Associates are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive care today. We feel a clear understanding of our policy is important to our professional relationship.

INSURANCE

As a courtesy to our patients, we gladly process your insurance claim. We participate in different insurance plans, but please inquire if we accept yours to avoid billing problems later. We *ESTIMATE* your deductible for the year and your portion due that is not covered insurance. The total Portion that is not covered by insurance is *DUE AT THE TIME OF YOUR APPOINTMENT*. Parents *MUST* send co-pays due with minors at the time of their appointment. Please initial _____

MISSED APPOINTMENTS/CANCELLATIONS

Twenty four (24) hour notice is required for cancellation of appointments. We reserve the right to charge a fee for broken appointments or ones that are not cancelled beforehand within a reasonable time frame. If repeated "No-Shows" occur, you will be charged $50.00 for care. Please initial _____

PAYMENT OPTIONS

1. Cash
2. Personal Checks
3. Visa, MasterCard, Discover and American Express
4. CARECREDIT: Offers patients a line of credit to over you or your family's dental care needs. In most important situations this is an interest free program for up to a year. This program is most helpful for allowing you to begin your treatment immediately and spread the cost over a period of time. Inquire with office staff to attain further information regarding the different programs they offer.
5. ClearGage: A program that will take monthly payments out of your bank account automatically so you will not have to worry about remembering to make a payment. Please see office staff to attain further information.

I understand and agree that, regardless of my insurance (if applicable), I am ultimately responsible for the balance on my account for all charges and services rendered. I have read all the information on this sheet.

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Print Name:_____

Patient Signature:_____ Date:_____

Guarantor Signature:_____ Date:_____

PREVIOUS DENTIST

Who was your previous dentist? _____

When was your last Dental cleaning? _____

When did you last have xrays? _____

Have you seen a Dental Specialist in the past year? _____ Yes _____ No

If yes, Who: _____

HIPAA

(Acknowledgement of receipt)

The **HIPAA PRIVACY RULE** establishes national standards to protect patients' health records and other personal health information and applies to health plans, health care clearinghouses and those health care providers that conduct health care transactions electronically.

I acknowledge that I have received a copy of Salmon Brook Dental Notice Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____